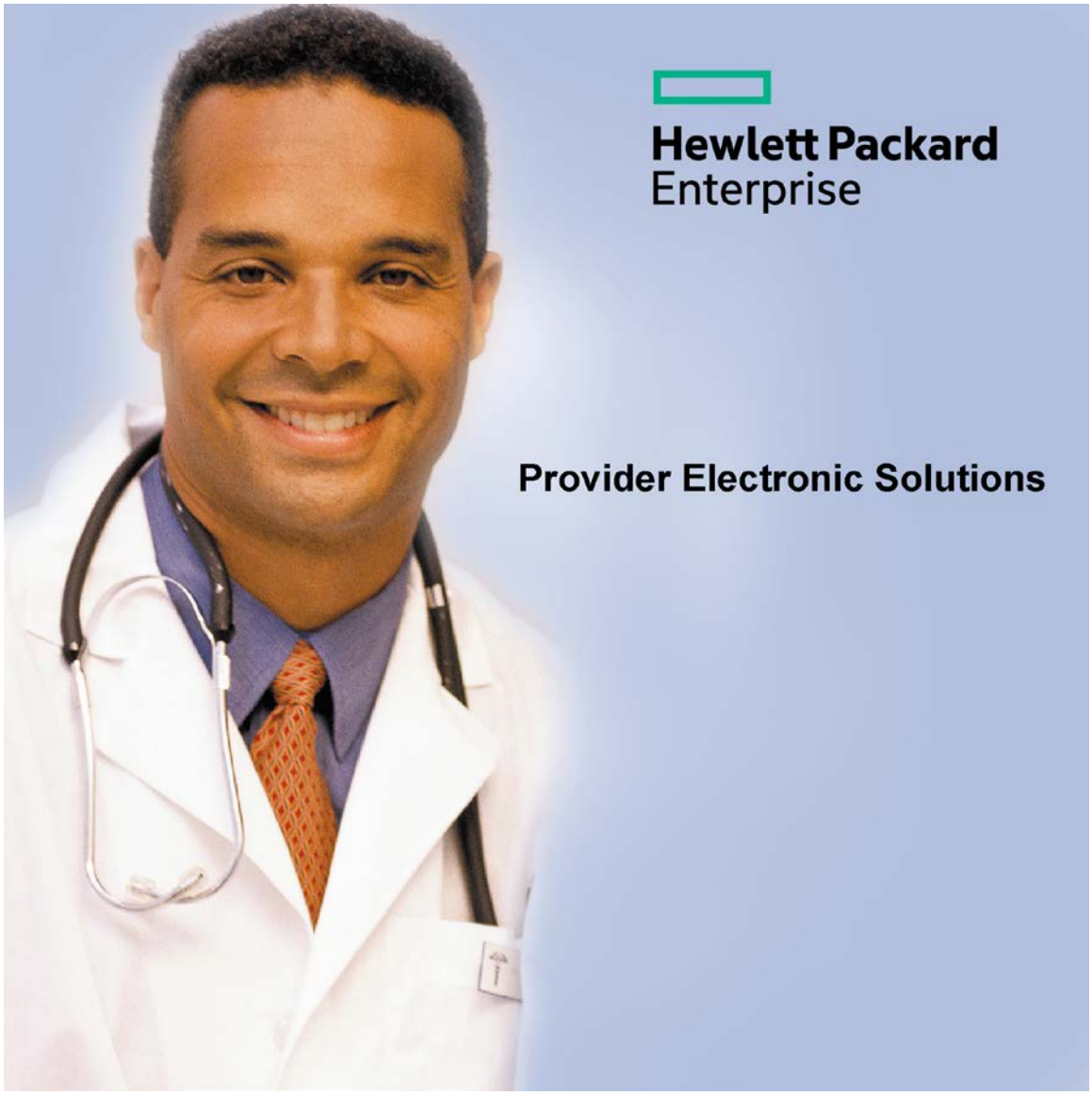
HPE Provider Electronic Solutions

Billing Instructions



Inpatient Claims

<u>Important Update:</u> This software will not be supported after October 1, 2015. Current PES users are encouraged to transition to an alternative method of claim submission by October 1, 2015 to avoid a disruption in electronic claims processing.

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INTRODUCTION

Now that you have installed and become familiar with the functionality of the Hewlett Packard Enterprise PROVIDER ELECTRONIC SOLUTIONS software, it's time to begin claims data entry.

The claim entry screen consists of eight sections: Five Header, One Service, Other Insurance and Crossover screens.

The following instructions detail requirements and general information for each section of your claim.

In the following sections, each data entry field is defined with the appropriate requirements. Edits have been built into the software to assist you in correct data entry, however, READ THESE SECTIONS CAREFULLY. Payment or denial of your claims depends on the data you supply to Hewlett Packard Enterprise.

Please reference your billing manual for detailed Connecticut Medical Assistance Program billing requirements unique to your provider type.

Important Update: **This software will not be supported after October 1, 2015. Current PES users are encouraged to transition to an alternative method of claim submission by October 1, 2015 to avoid a disruption in electronic claims processing.**

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit screens. For example, you can enter lists of common diagnosis codes, procedure codes, type of bill and admission source and type. All of the lists are available from the data entry section as a drop-down list where you can select previously entered data to speed the data entry process and help ensure accuracy of the form.

There are several lists that you are required to complete prior to entering a transaction. Because this software uses the HIPAA-compliant transaction format, there is certain information, which is required for each transaction. To assist you in making sure that all required information is included and to save time entering your information, some of the lists are required. These lists are:

- Client
- Billing Provider
- Other Provider
- Taxonomy
- Policy Holder

If these lists are not completed prior to keying your transaction, the list will open in the transaction form.

Some of the lists contain preloaded information that is available for auto-plugging as soon as you install Provider Electronic Solutions. Other lists require you to enter the information you will use for auto-plugging. You should enter your data in these lists soon after you set up Provider Electronic Solutions to take advantage of the auto-plug feature. To create or edit a list, select List from the Main Menu and then select the appropriate item.

Working with Lists

From the Lists option on the menu bar, select the list you want to work with.

Perform one of the following:

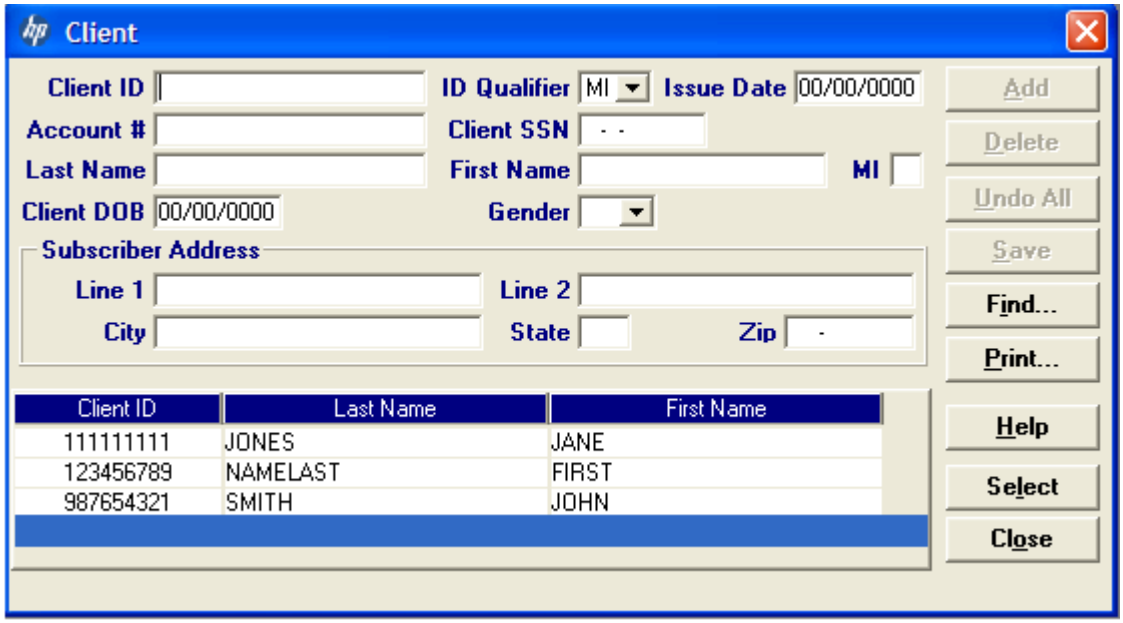
· To add a new entry, select Add.

· To edit an existing entry, select the entry and then enter your changes.

· The command buttons for Delete, Undo All, Find, Print, and Close work as titled.

Note: The Select command button is not visible on the List window unless it has been invoked by double-clicking an auto-plug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

CLIENT SCREEN



The Client list requires you to collect detailed information about your clients, which is then automatically entered into forms. All of the fields are required except Account Number, Middle Initial, Issue Date and Subscriber Address Line 2.

CLIENT ENTRY INSTRUCTIONS

Client ID:
Enter the Client Identification Number assigned by the Connecticut Medical Assistance Program.

ID Qualifier:
This field has been preloaded with the information which identifies the type of client. This field will be by-passed.

Issue Date:
Enter the issue date found on the patient's Medical Assistance Program Identification Card.

Account #:
Enter the unique number assigned by your facility to identify a client.

Client SSN:
Enter the client's social security number.

Last Name:
Enter the last name of the client who received services.

First Name:
Enter the first name of the client who received services.

MI:
Enter the middle initial of the client who received services.

Client DOB:
Enter the date the client was born.

Gender:
Select the appropriate value from the drop-down list to enter the client's gender.

Code	Description
F	Female
M	Male
U	Unknown

Subscriber Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, clients and policyholders.

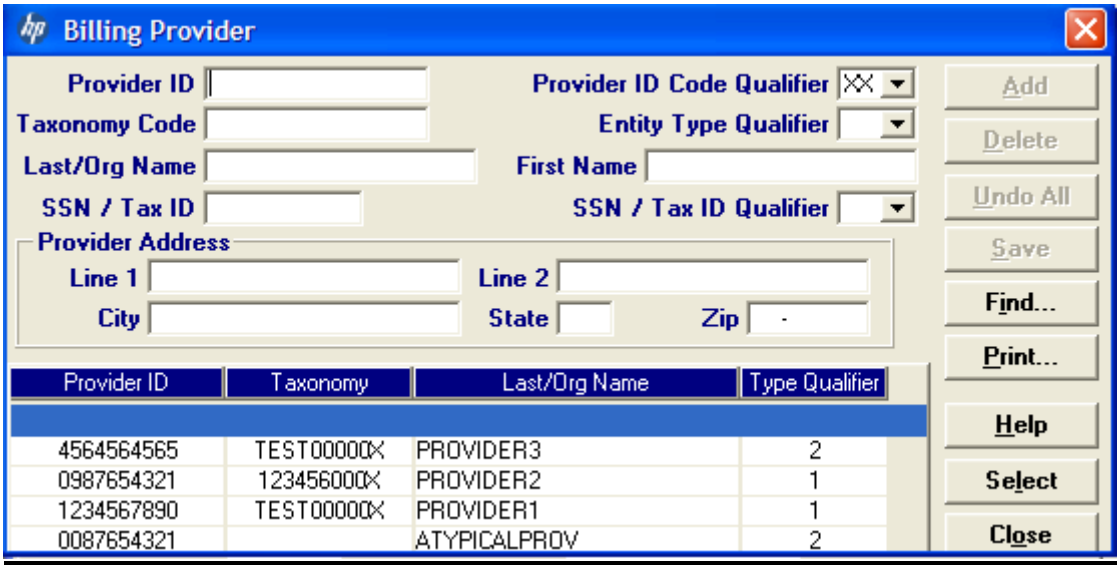
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip:
Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

BILLING PROVIDER SCREEN



The Provider list requires you to collect information about service providers, which is then automatically entered into forms. These can be individual providers or organizations. Use this list to enter all billing provider, and Medicare rendering provider numbers. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

BILLING PROVIDER ENTRY INSTRUCTIONS

Provider ID:
Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:
Enter the code that identifies if the Provider ID submitted is the Connecticut Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:
An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier
Select the appropriate value to indicate if you are an individual performer or corporation.

Last/Org Name:
Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when they are an individual. Required when the Entity Type Qualifier is a 1. This field will not be available when the Entity Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number or Tax Identification number of the party being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop-down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

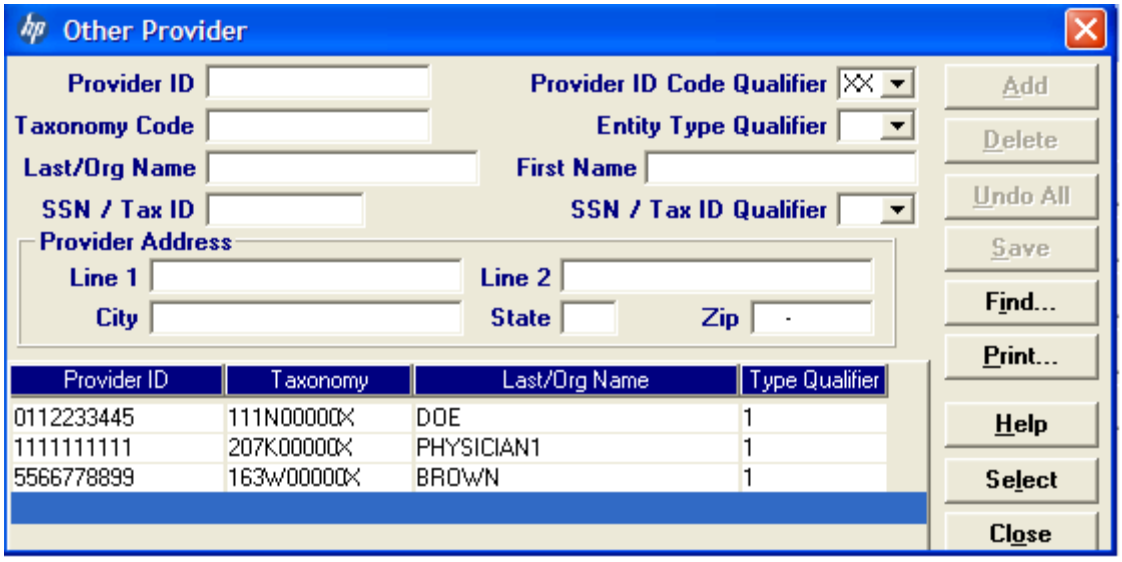
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number. The address is required for providers, subscribers and policyholders.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

OTHER PROVIDER SCREEN



The Other Provider list requires you to collect information about non-billing providers, which is then automatically entered into forms. Enter the attending, operating and other Medical Assistance provider numbers in this list. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

OTHER PROVIDER ENTRY INSTRUCTIONS

Provider ID:
Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:
Enter the code that identifies if the Provider ID submitted is the Connecticut Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:
An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com

Entity Type Qualifier
Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:
Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Entity Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop-down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

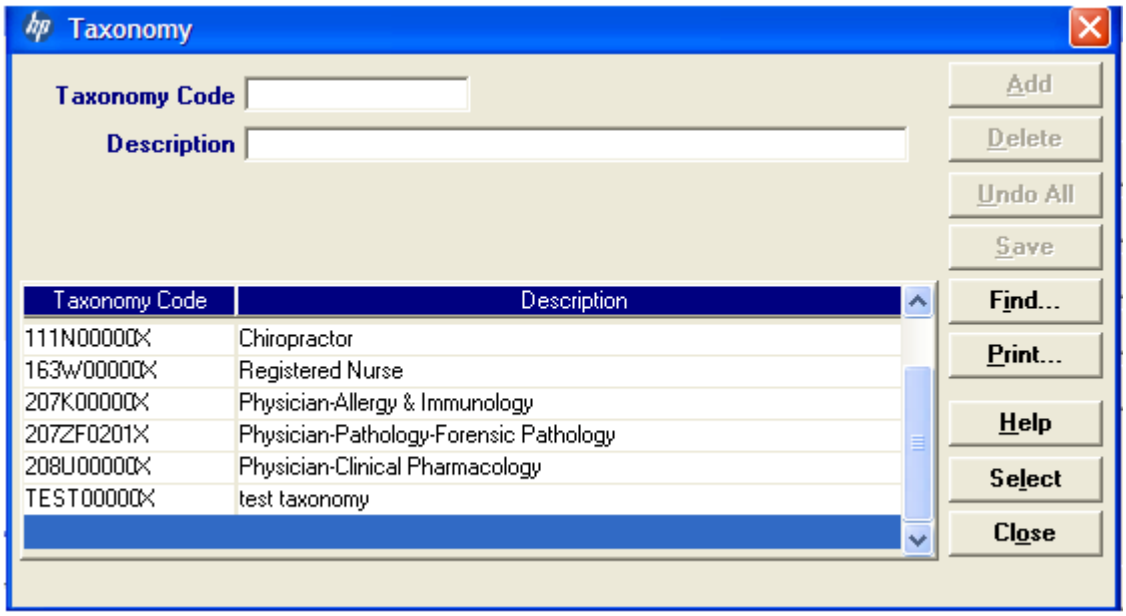
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

TAXONOMY SCREEN



The Taxonomy list requires you to enter the taxonomy code, which is then automatically entered into the Provider List. All fields are required.

TAXONOMY BILLING INSTRUCTIONS

Taxonomy Code:

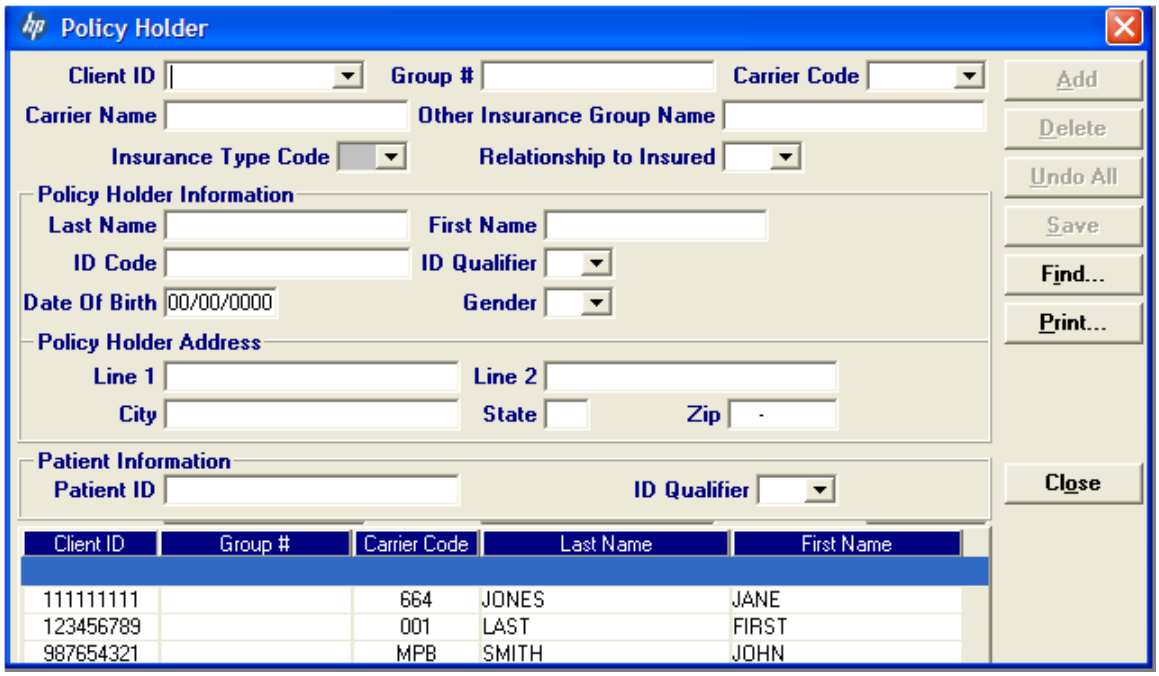
An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Description:

Enter the description of the code listed.

POLICY HOLDER SCREEN



The Policy Holder list requires you to enter the information for the policyholder of the other insurance policies and Medicare policies. As with the provider and client lists, this list must be completed before entering a claim with other insurance or Medicare. Complete a separate list for each policy when a client has both other insurance and Medicare. Like the other lists, once the code is entered into the list, it may be accessed by the drop-down window and will automatically populate into the claim. All fields are required except Policy Holder Address Line 2.

POLICY HOLDER ENTRY INSTRUCTIONS

The information on this screen must be entered before you enter the Group Number located on the Other Insurance screen.

Client ID:

Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

Group Number:

Enter group number for other insurance or Medicare. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Carrier Code:

Select the 3-digit other insurance carrier code from the drop-down box. This field is required if an indicator of Y is entered in the other insurance indicator field on the Header Five screen. Note: Provider must maintain an Explanation of Benefit (EOB) on file for audit purposes.

Carrier Name:

This field is auto-plugged by the system once the carrier code is entered and contains the name of the other insurance company listed for the client.

Other Insurance Group Name:

Enter the name of the group that the other insurance is listed under and coincides with group number.

Insurance Type Code:
Select the appropriate value from the drop-down box that identifies the type of insurance listed.

Relationship to Insured:
Select the appropriate value from the drop-down box that identifies the client's relationship to the policy-holder for the other insurance or Medicare listed. If the client is the policyholder, self will be selected.

Last Name:
Enter the last name of the policyholder of the other insurance or Medicare.

First Name:
Enter the first name of the policyholder of the other insurance or Medicare.

ID Code:
Enter the policyholder's identification number assigned by the other insurance company or Medicare.

ID Qualifier:
Select the appropriate value from the drop-down box that identifies the ID that is being used.

Date of Birth:
Enter the date the policyholder was born.

Gender:
Select the appropriate value from the drop-down box that identifies the sex of the individual.

Policy Holder Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

Patient ID:
Enter the other insurance identification number of the Connecticut Medical Assistance Program client for whom services are being billed.

ID Qualifier:
Select the appropriate value from the drop-down box that identifies the ID that is being used.

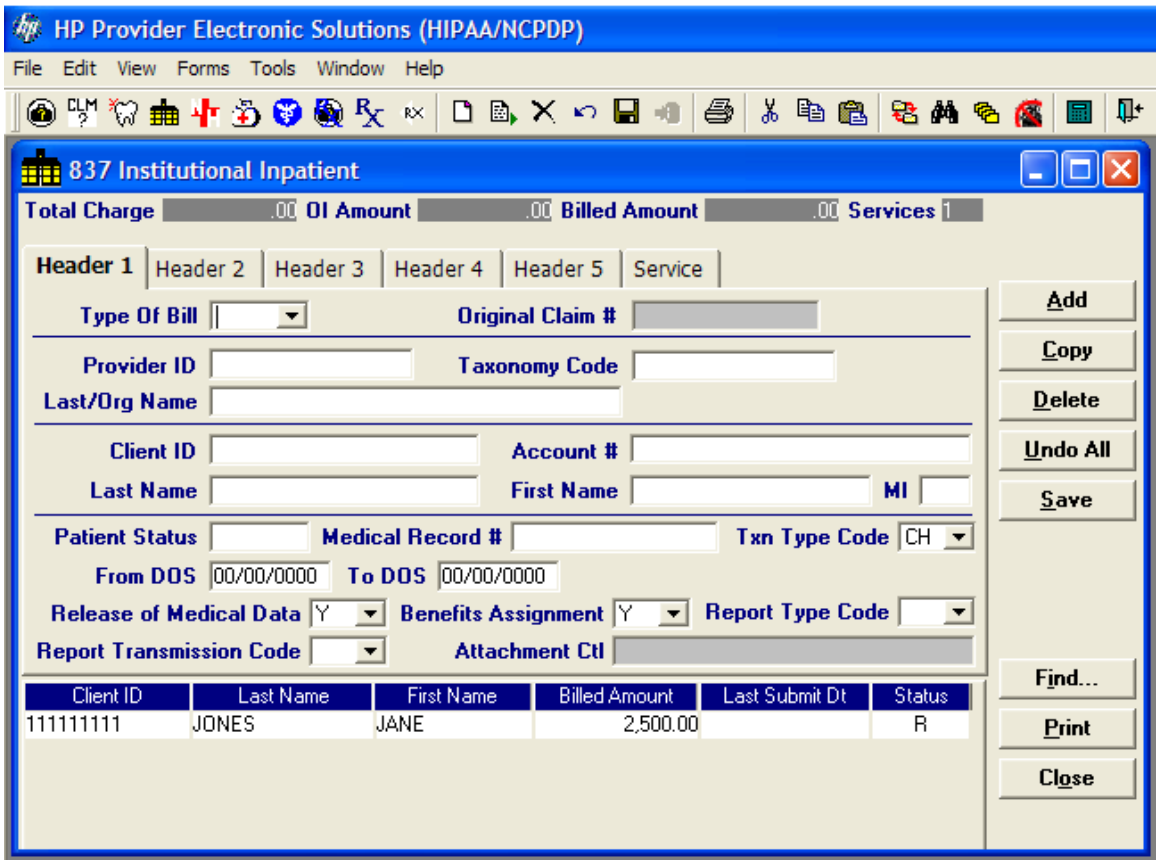
CLAIM ENTRY INSTRUCTIONS

Use the following instructions to complete the claim screens. When data entry is complete, click **SAVE.** The saved claim will appear in the list below the data entry screen. If the claim data hits edits, a message window will appear with error messages. Click **SELECT** to move to the highlighted error and correct the data. Once all error messages have been resolved, you can save the claim.

Newly saved claims are in Status R (Ready). Status R claims can be edited and saved multiple times prior to submission. Be sure to click **ADD** before beginning to enter the data for each new claim.

Note: The Select command button is not visible on the List window unless it has been invoked by double-clicking an auto-plug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

INPATIENT HEADER ONE



HEADER ONE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
TYPE OF BILL	3	R	N
ORIGINAL CLAIM #	13	S	N
PROVIDER ID	10	R	N
TAXONOMY CODE	10	R	X
LAST/ORG NAME	35	R	A
CLIENT ID	16	R	X
ACCOUNT NUMBER #	38	R	X
LAST NAME	35	R	A
FIRST NAME	25	R	A
MI	1	O	A
PATIENT STATUS	2	R	N
MEDICAL RECORD #	30	O	X
TXN TYPE CODE	2	R	A
FROM DOS	8	R	N
TO DOS	8	R	N
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
REPORT TYPE CODE	2	O	X
REPORT TRANSMISSION CODE	2	O	A
ATTACHMENT CTL	30	S	X

A = ALPHA N = NUMERIC X = ALPHANUMERIC

HEADER ONE ENTRY INSTRUCTIONS

Special Note: All data entry will default to capital letters.

Header Field Definition

$$ = Dollars
cc = Cents
A = Alpha
N = Numeric
X = Alphanumeric

Type of Bill:

Enter the 3-digit code that identifies the type of bill. The code identifies the type of facility and the bill classification.

First digit indicates facility.

Code	Description
1	Hospital

Second Digit indicates the Bill Classification.

Code	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)

Third Digit indicates the Frequency.

Code	Description
0	Non-payment / Zero Claim
1	Admit through discharge date
2	First interim claim
3	Continuing Interim claim
4	Last interim claim
7	Replacement of prior claim (designates electronic adjustment)
8	Void/Cancel of prior claim (designates electronic adjustment)

Note: If the third digit is a "7" or "8", the Original Claim field will be required.

Remarks: Required
Format: NNN

Original Claim #:
This field is populated when the last digit on the Type of Bill is a "7" or "8". When a claim is replaced or voided, indicate the original Internal Control Number as it appears on the remittance advice.

Remarks: Situational
Format: NNNNNNNNNNNNN

Provider ID:
Enter your NPI or Connecticut Medical Assistance Program Provider number with two leading zeros.

Remarks: Required
Format: NNNNNNNNNN

Taxonomy Code:
This field will be auto-plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case. This field is entered when entering your provider number under the lists menu. This field will be auto-plugged once you enter your provider number.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Last/Org Name:
This field will be auto-plugged once you enter your provider number and contains the provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Programs.

Example: THOMPSON or 'TH'
Remarks: Required

Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
or AA

Client ID:

Enter the client's 9-digit Connecticut Medical Assistance Program identification number.

Remarks: Required
Format: NNNNNNNNN

Account #:

Enter the patient's account number. Provider assigned, this field may be alphabetic or numeric and is used for the provider's own accounting purposes.

Remarks: Required
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Name:

This field is auto-plugged when the client ID is entered and contains the client's last name or the first two characters of the client's last name.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
or AA

First Name:

This field is auto-plugged when the client ID is entered and contains the client's first name or the first character of the client's first name. There are no spaces allowed in this field.

Example: JOHN or 'J'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAA or A

MI:

This field is auto-plugged when the client ID is entered and contains the first character of the client's middle name.

Example: 'J'
Remarks: Optional
Format: A

Patient Status:

Enter the appropriate patient status code as of the through date from the table below:

Code	Description
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital
03	Discharged/transferred to a skilled nursing facility
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to another type of institution

06	Discharged/transferred to home, under care of organized home health service organization
07	Left against medical advice
08	Discharged/transferred to home under the care of home IV provider
09	Admitted as an inpatient to this hospital
20	Expired or did not recover
30	Still a patient
40	Expired at home
41	Expired in medical facility
42	Expired – place unknown
50	Hospice – home
51	Hospice – medical facility
61	Discharge/transferred within this institution to hospital-based Medicare approved swing bed

Remarks: Required
Format: NN

Medical Record #:

Enter the number assigned to the patient's record.

Remarks: Optional
Format: XXXXXXXXXXXXXXXX

Transaction Type Code:

Select the appropriate code from the drop-down list indicating the type of transaction being sent.

Code	Description
CH	Chargeable
RP	Reporting

Remarks: Required
Format: AA

From DOS:

Enter the first date of service on which services were provided for this claim

Remarks: Required
Format: MM/DD/CCYY

To DOS:

Enter the last date of service on which services were provided for this claim.

Remarks: Required
Format: MM/DD/CCYY

Release of Medical Data:

This code indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. Enter the value that corresponds to the release of the medical data:

Code	Description
I	Informed consent to release medical information. For conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Remarks: Required
Format: A

Benefits Assignment:

Code identifying that the client, or authorized person, authorizes benefits to be assigned to the provider. Enter one of the values below to indicate assignment of benefits.

Y – Yes
N - No

Remarks: Required
Format: A

Report Type Code:

Code indicating the title or contents of a document, report or supporting item for this claim
Enter the two-digit value that corresponds to the report type.

Code	Description
03	Report justifying treatment beyond utilization guidelines
04	Drugs Administered
05	Treatment diagnosis
06	Initial assessment
07	Functional goals
08	Plan of treatment
09	Progress report
10	Continued treatment
11	Chemical analysis
13	Certified test report
15	Justification for admission
21	Recovery plan
A3	Allergies/sensitivities document
A4	Autopsy report
AM	Ambulance certification
AS	Admission summary
B2	Prescription
B3	Physician order
B4	Referral form
BR	Benchmark testing results
BS	Baseline
BT	Blanket test results
CB	Chiropractic justification
CK	Consent form(s)
CT	Certification
D2	Drug profile document
DA	Dental models
DB	Durable medical equipment prescription

DG	Diagnostic report
DJ	Discharge monitoring report
DS	Discharge summary
EB	Explanation of benefits
HC	Health certificate
HR	Health clinic records
I5	Immunization record
IR	State school Immunization records
LA	Laboratory results
M1	Medical record attachment
MT	Models
NN	Nursing notes
OB	Operative Notes
OC	Oxygen content averaging report
OD	Orders and treatments document
OE	Objective physical examination (including vital signs) document
OX	Oxygen therapy certification
OZ	Support data for claim
P4	Pathology report
P5	Patient medical history document
PE	Parenteral or enteral certification
PN	Physical therapy notes
PO	Prosthetics or orthotic certification
PQ	Paramedical results
PY	Physician's report
PZ	Physical therapy certification
RB	Radiology films
RR	Radiology reports
RT	Report of tests and analysis report
RX	Renewable oxygen content averaging report
SG	Symptoms document
V5	Death notification
XP	Photographs

Remarks: Optional
Format: XX

Report Transmission Code:

Code defining timing, transmission method or format by which reports are to be sent. Enter the two digit value that defines the transmission method reports will be sent:

Code	Description
AA	Available on Request at Providers Site
BM	By mail
EL	Electronically only
EM	E-mail
FT	File Transfer
FX	By fax

Note: If the values BM, EL, EM, FT or FX are used, the Attachment Control field will be required.

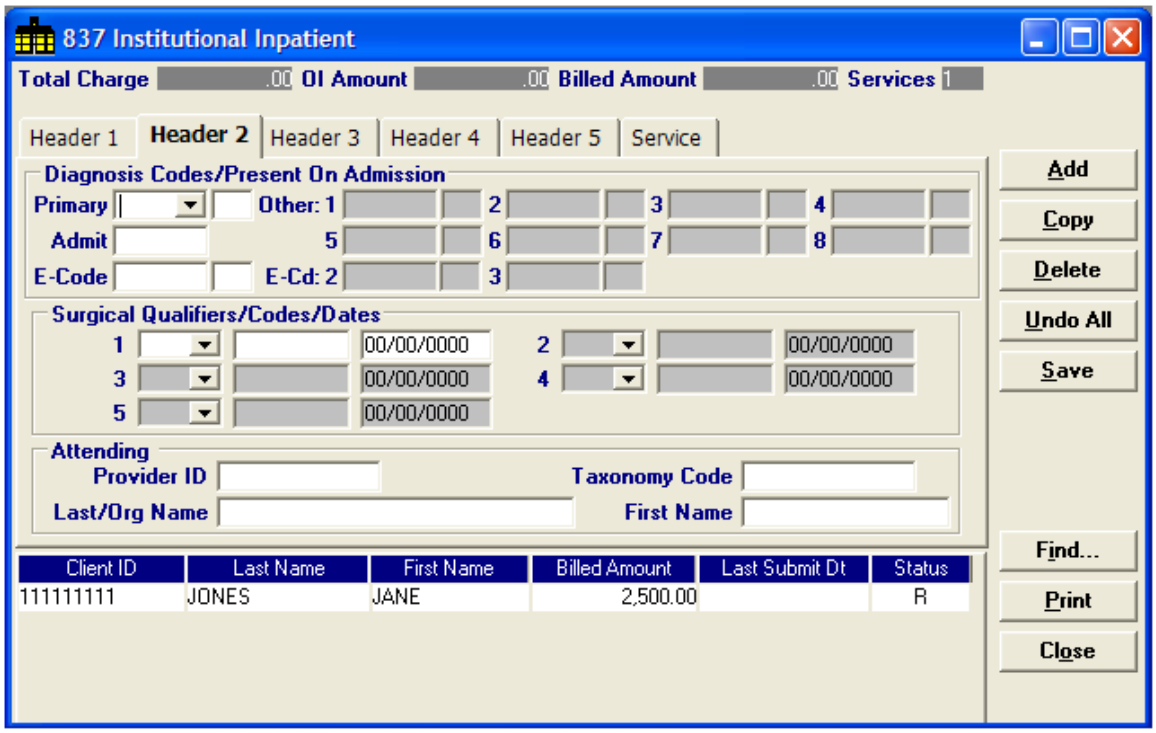
Remarks: Optional
Format: AA

Attachment CTL:

This field is enabled when the Report Transmission Code is a “BM”, “EL”, “EM”, “FT” or “FX”. Enter the control number of the attachment.

Remarks: Situational
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

INPATIENT HEADER TWO



HEADER TWO INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DIAGNOSIS CODES PRIMARY	5	R	X
PRESENT ON ADMISSION	1	R	A
DIAGNOSIS CODES OTHER 1-8	5	R	X
DIAGNOSIS CODES ADMIT	5	R	X
DIAGNOSIS CODES E-CODE 1-3	5	O	X
SURGICAL QUALIFIERS 1-5	2	S	A
SURGICAL CODES 1-5	5	S	X
SURGICAL DATES 1-5	8	S	N
ATTENDING PROVIDER ID	10	R	N
ATTENDING TAXONOMY CODE	10	R	X
ATTENDING LAST/ORG NAME	35	R	A
ATTENDING FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

HEADER TWO ENTRY INSTRUCTIONS

Diagnosis Codes Primary:

Enter the primary diagnosis code from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) manual. Note: DO NOT key the decimal point. It is already assumed.

Remarks: Required
Format: XXXXX

Present on Admission:

Select the appropriate indicator from the drop-down list to indicate whether the diagnosis was present at the time the patient was admitted. Required for each diagnosis reported.

Y – Yes
N – No
U – Unknown
` **W** – Clinically undetermined

Remarks: Required
Format: A

Diagnosis Codes Other 1-8:

Enter up to eight ICD-9-CM three, four or five-digit diagnosis codes for a diagnosis other than the principal diagnosis. Note: DO NOT key the decimal point. It is already assumed.

Remarks: Optional
Format: XXXXX

Diagnosis Codes Admit:

Enter the ICD-9-CM diagnosis code corresponding to the diagnosis of the client's condition, which prompted admission to the hospital.

Remarks: Required
Format: XXXXX

Diagnosis Codes E-Code 1-3:

Enter the appropriate diagnosis code, beginning with "E" whenever there is a diagnosis of an injury, poisoning, or adverse effect.

Remarks: Optional
Format: XXXXX

Surgical Qualifiers 1-5:

When a surgical procedure code is billed, select the appropriate procedure code qualifier from the drop-down list.

Code	Description
BR	Principle procedure – ICD-9
BQ	Other Procedure – ICD –9

Remarks: Situational
Format: AA

Surgical Codes 1-5:

Once the qualifier is selected enter the ICD-9 surgical procedure code. Then enter the date that the procedure was performed.

Remarks: Situational
Format: XXXXX

Surgical Dates 1-5:

Enter the date that the procedure was performed.

Remarks: Situational
Format: MM/DD/CCYY

Attending Provider ID

Enter the NPI or Connecticut Medical Assistance Program Provider number with two leading zeros of the party being referenced. Use the List from the menu to enter the information before submitting your claim.

Note: Once you have entered the Attending Provider ID the Taxonomy Code, Last/Org Name and First Name will be populated automatically.

Remarks**:** Required
Format: NNNNNNNNNN

Attending Taxonomy Code:

This field will be auto-plugged once you enter the Attending Provider ID and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Attending Last/Org Name:

This field will be auto-plugged once you enter the Attending Provider ID and contains the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

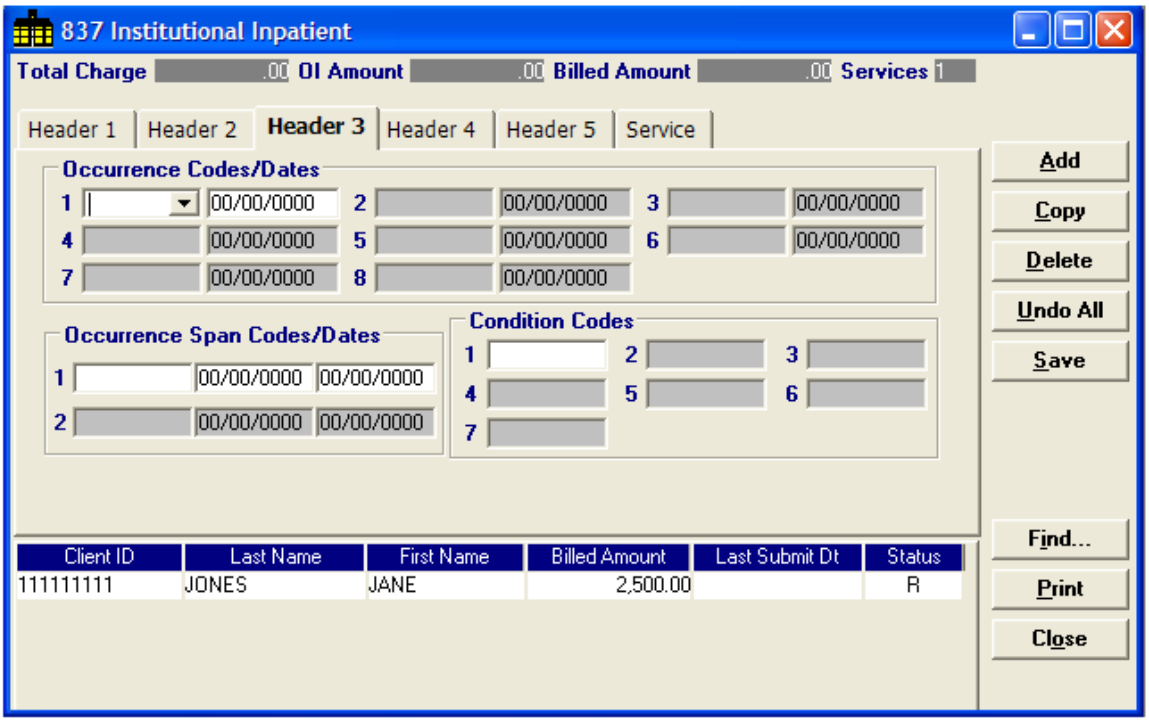
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Attending First Name:

This field will be auto-plugged once you enter the Attending Provider ID and contains the first name of the provider when they are an individual. Required when the Entity Type Qualifier is a 1. Field is not available when the Entity Type Qualifier is a 2.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAA

INPATIENT HEADER THREE



HEADER THREE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
OCCURRENCE CODES 1-8	2	S	N
OCCURRENCE CODE DATES 1-8	8	S	N
OCCURRENCE SPAN CODES 1-2	2	S	N
OCCURRENCE SPAN DATES 1-2	8	S	N
CONDITION CODES 1-7	2	S	X

A = ALPHA N = NUMERIC X = ALPHANUMERIC

HEADER THREE ENTRY INSTRUCTIONS

Occurrence Codes 1-8:

Enter the applicable code that identifies a significant event relating to this stay. Up to eight occurrence codes can be entered with a corresponding date.

Code	Description
01	Auto Accident (out of state accident)
02	Auto Accident (used for no fault)
03	Accident Tort Liability – if known
04	Accident Employment Related
05	Type of Accident Other than 01 - 04
06	Crime Victim

11	Onset of Symptoms/Illness
21	Administratively Necessary Days

Remarks: Situational
Format: NN

Occurrence Code Dates 1-8:

Enter the date associated with the code listed.

Remarks: Situational
Format: MM/DD/CCYY

Occurrence Span Codes 1-2:

Enter the Occurrence span code.

Remarks: Optional
Format: NN

Occurrence Span Dates 1-2:

Enter the date associated with the code listed.

Remarks: Optional
Format: MM/DD/CCYY

Condition Codes 1-7:

Enter the appropriate condition codes to identify conditions that determine eligibility and establish primary and/or secondary responsibility. The following codes are applicable to the Connecticut Medical Assistance Program.

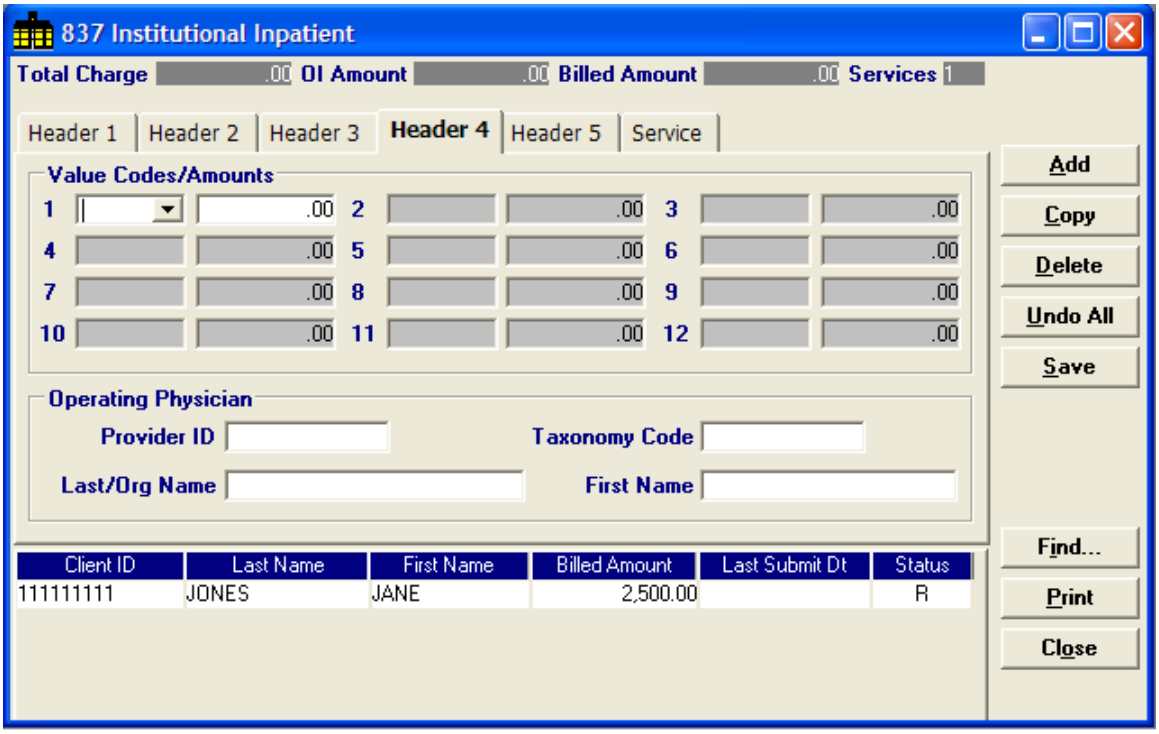
Code	Description
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Shown on Claim
05	Lien Has Been Filed
A1	EPSDT
A4	Family Planning

NOTE: The condition codes listed below should only be used if an abortion was performed due to rape, incest, or life endangerment.

Code	Description
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AD	Abortion performed due to a life endangering physical condition caused by or arising from pregnancy itself
A7	Induced abortion endangerment to life
A8	Induced abortion victim of rape/incest

Remarks: Situational
Format: XX

INPATIENT HEADER FOUR



HEADER FOUR INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
VALUE CODES 1-12	2	S	X
VALUE CODE AMOUNTS 1-12	9	S	N
OPERATING PHYSICIAN PROVIDER ID	10	S	X
OPERATING PHYSICIAN TAXONOMY CODE	10	S	X
OPERATING PHYSICIAN LAST/ORG NAME	35	S	A
OPERATING PHYSICIAN FIRST NAME	25	S	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

HEADER FOUR ENTRY INSTRUCTIONS

Value Codes 1-12:

Enter the applicable code that identifies a significant event relating to this stay. Up to twelve value codes can be entered with a corresponding date.

Remarks: Situational
Format: XX

Value Code Amounts 1-12:

Enter the corresponding value code amount.

Remarks: Situational
Format: $$$$$$$cc

Operating Physician Provider ID:

Enter the NPI or Connecticut Medical Assistance Program Provider number with two leading zeros of the party being referenced. Use the List from the menu to enter the information before submitting your claim.

Note: Once you have entered the Operating Provider ID the Taxonomy Code, Last/Org Name and First Name will be populated automatically.

Remarks**:** Required
Format: NNNNNNNNNN

Operating Physician Taxonomy Code:

This field will be auto-plugged once you enter the Operating Provider ID and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Situational
Format: NNNANNNNNA

Operating Physician Last/Org Name:

This field will be auto-plugged once you enter the Operating Provider ID and contains the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

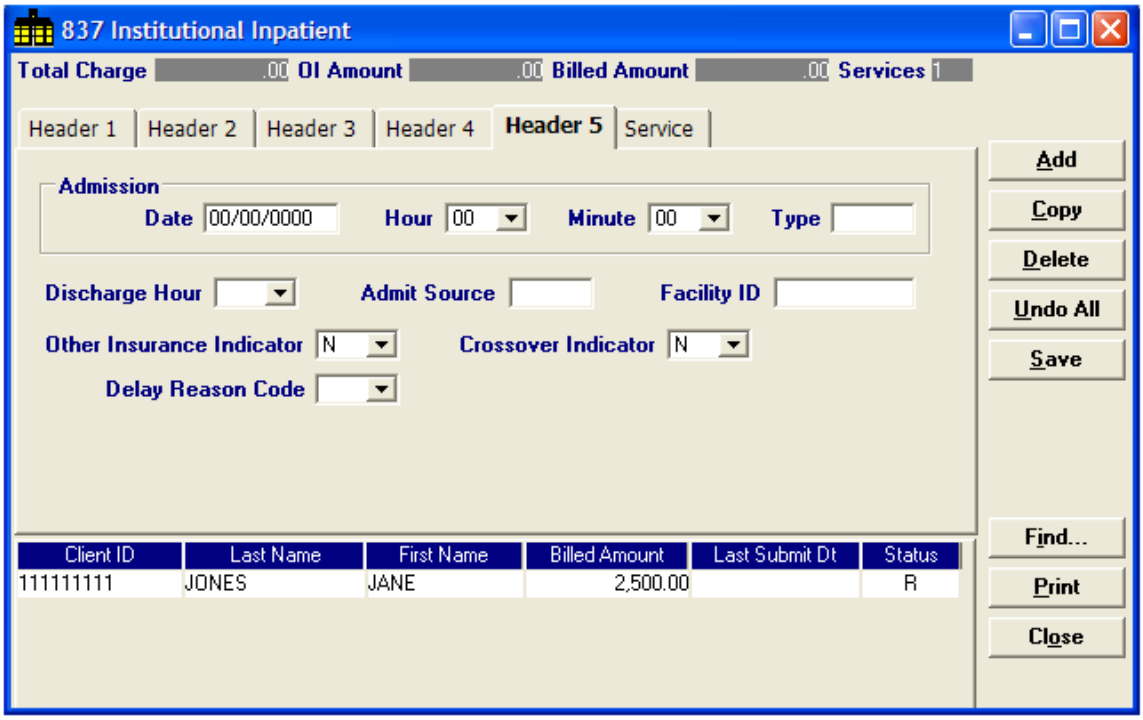
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Operating Physician First Name:

This field will be auto-plugged once you enter the Operating Provider ID and contains the first name of the provider when they are an individual. Required when the Entity Type Qualifier is a 1. Field is not available when the Entity Type Qualifier is a 2.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAA

INPATIENT HEADER FIVE



HEADER FIVE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
ADMISSION DATE	8	R	N
ADMISSION HOUR	2	R	N
ADMISSION MINUTE	2	R	N
ADMISSION TYPE	1	R	N
DISCHARGE HOUR	2	S	N
ADMIT SOURCE	1	R	X
FACILITY ID	10	R	N
OTHER INSURANCE INDICATOR	1	S	A
CROSSOVER INDICATOR	1	S	A
DELAY REASON CODE	1	O	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

HEADER FIVE ENTRY INSTRUCTIONS

Admission Date:

Enter the admission date associated with the period being submitted. This date cannot be greater than the "From DOS" on the Header 1 tab.

NOTE: This software will not accept dates of service prior to 1976. Therefore, if the client's admission date is prior to 1976, please enter the admission date as 01/01/1976.

Remarks: Required
Format: MM/DD/CCYY

Admission Hour:

Select the appropriate value that corresponds to the hour during which the client was admitted for inpatient care. Field defaults to '00'.

Code	Description	Code	Description
00	12:00 – 12:59AM Midnight	12	12:00 – 12:59PM Noon
01	1:00 - 1:59AM	13	1:00 - 1:59PM
02	2:00 - 2:59AM	14	2:00 - 2:59PM
03	3:00 - 3:59AM	15	3:00 - 3:59PM
04	4:00 - 4:59AM	16	4:00 - 4:59PM
05	5:00 - 5:59AM	17	5:00 - 5:59PM
06	6:00 - 6:59AM	18	6:00 - 6:59PM
07	7:00 - 7:59AM	19	7:00 - 7:59PM
08	8:00 - 8:59AM	20	8:00 - 8:59PM
09	9:00 - 9:59AM	21	9:00 - 9:59PM
10	10:00 – 10:59AM	22	10:00 – 10:59PM
11	11:00 – 11:59AM	23	11:00 – 11:59PM

Remarks: Optional
Format: NN

Admission Minute:

Select the appropriate value that corresponds to the minute during which the client was admitted for inpatient care. Field defaults to '00'.

Code	Code	Code	Code	Code	Code
00	11	22	33	44	55
01	12	23	34	45	56
02	13	24	35	46	57
03	14	25	36	47	58
04	15	26	37	48	59
05	16	27	38	49	
06	17	28	39	50	
07	18	29	40	51	
08	19	30	41	52	
09	20	31	42	53	
10	21	32	43	54	

Remarks: Required
Format: NN

Admission Type:

Select the appropriate value that corresponds to the primary admission reason.

Code	Description
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Transfer
6	Re-admission
9	Information not available

Remarks: Required
Format: N

Discharge Hour:

Select the appropriate value that corresponds to the hour during which the client was discharged for inpatient care.

Code	Description	Code	Description
00	12:00 – 12:59AM Midnight	12	12:00 – 12:59PM Noon
01	1:00 - 1:59AM	13	1:00 - 1:59PM
02	2:00 - 2:59AM	14	2:00 - 2:59PM
03	3:00 - 3:59AM	15	3:00 - 3:59PM
04	4:00 - 4:59AM	16	4:00 - 4:59PM
05	5:00 - 5:59AM	17	5:00 - 5:59PM
06	6:00 - 6:59AM	18	6:00 - 6:59PM
07	7:00 - 7:59AM	19	7:00 - 7:59PM
08	8:00 - 8:59AM	20	8:00 - 8:59PM
09	9:00 - 9:59AM	21	9:00 - 9:59PM
10	10:00 – 10:59AM	22	10:00 – 10:59PM
11	11:00 – 11:59AM	23	11:00 – 11:59PM

Remarks: Situational
Format: NN

Admit Source:

Select the appropriate value that corresponds to the source of admission.

Code	Description
1	Physician referral
2	Clinic referral
3	HMO
4	Transfer from hospital
5	Transfer from SNF
6	Transfer from another health facility
7	Emergency room
8	Court, Law
A	Transfer from a critical hospital

Admit Source (continued):

Select the appropriate value that corresponds to the source of admission.

New Born (If the admission type has a value of 4)

Code	Description
1	Normal delivery
2	Premature delivery
3	Sick baby
4	Extramural birth
5	Born inside hospital
6	Born outside hospital

Remarks: Required
Format: X

Facility ID:

Select the Connecticut Medical Assistance Program provider number from the drop down box that identifies the facility where services were performed.

Remarks: Optional
Format: NNNNNNNNNN

Other Insurance Indicator:

This field indicates whether the client has other insurance or when Medicare does not pay any portion of the claim. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Other Insurance Tab is added to the claim form for entry.

Y – Yes
N – No

Remarks: Situational
Format: A

Crossover Indicator:

This field should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Crossover Tab is added to the claim form for entry. Use this field for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Remarks: Situational
Format: A

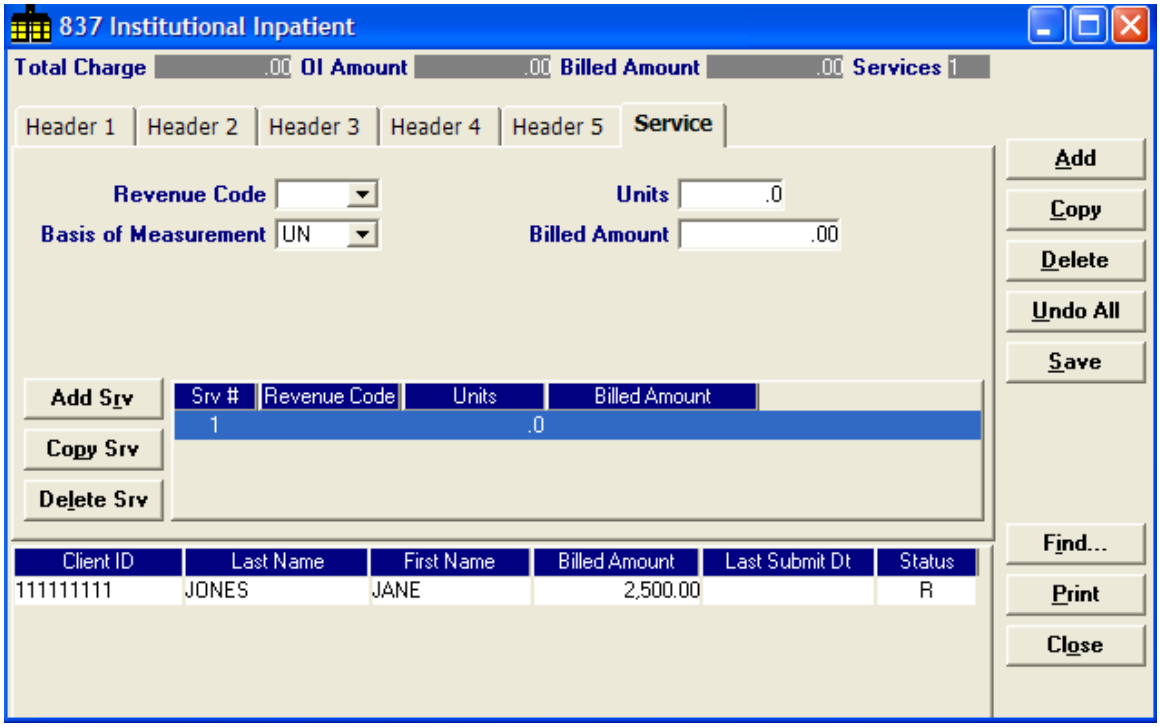
Delay Reason Code:

Select the appropriate code from the drop-down list that identifies the reason for delay in submitting the claim.

Code	Description
1	Proof of eligibility unknown or unavailable
2	Litigation
3	Authorization delays
4	Delay in certifying provider
5	Delay in supplying billing forms
6	Delay in delivery of custom-made appliances
7	Third party processing delay
8	Delay in eligibility determination
9	Original claim rejected or denied due to a reason unrelated to the billing limitation rules
10	Administration delay in the prior approval process
11	Other
15	Natural Disaster

Remarks: Optional
Format: N

INPATIENT SERVICE



SERVICE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
REVENUE CODE	3	R	N
BASIS OF MEASUREMENT	2	R	A
UNITS	5	R	N
BILLED AMOUNT	9	R	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

SERVICE ENTRY INSTRUCTIONS

Please NOTE: If the intent for this claim is to obtain coinsurance and deductible payments form a claim paid by Medicare, please complete this section as though you were submitting this claim to Medicare.

Revenue Code:

Enter the revenue center code (RCC) for the appropriate accommodation and ancillary services provided.

NOTE: See the Connecticut Uniform Billing Committee (CUBC) manual for all possible codes.

Inpatient hospital claims must be billed with the accommodation RCCs for which DSS has assigned rates.

Remarks: Required
Format: NNN

Basis of Measurement:

Enter the code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken. This field defaults to 'UN'.

Code	Description
DA	Days (Institutional)
UN	Unit (Institutional and Professional)

Remarks: Required
Format: XX

Units:

Enter the number of days being billed for the Revenue Center Code (RCC).

NOTE: For accommodation days, the sum of all the detail days must equal the days indicated.

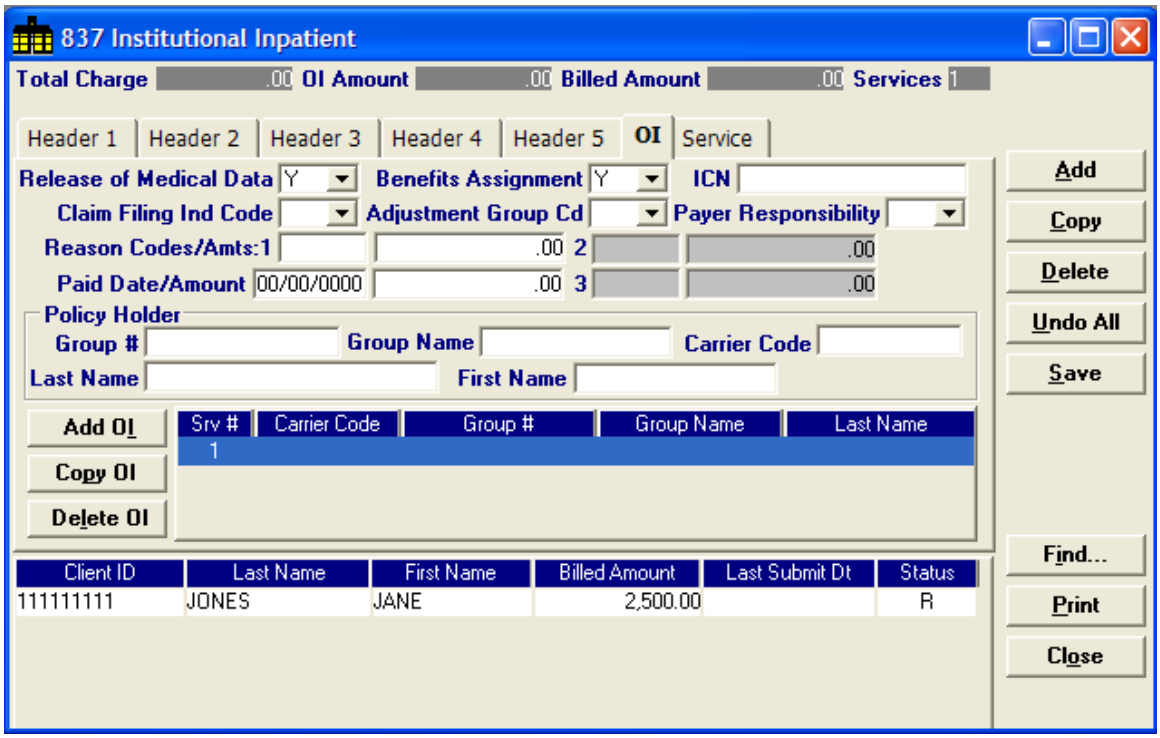
Remarks: Required
Format: NNNNN

Billed Amount:

Enter the total amount for the services performed for this procedure. This should include the charge for all units listed.

Remarks: Required
Format: $$$$$$$cc

OTHER INSURANCE


837 Institutional Inpatient
Total Charge .00 OI Amount .00 Billed Amount .00 Services 1
Header 1 Header 2 Header 3 Header 4 Header 5 OI Service
Release of Medical Data Y Benefits Assignment Y ICN
Claim Filing Ind Code Adjustment Group Cd Payer Responsibility
Reason Codes/Amts:1 .00 2 .00
Paid Date/Amount 00/00/0000 .00 3 .00
Policy Holder
Group # Group Name Carrier Code
Last Name First Name
Add OI
Copy OI
Delete OI
Srv # Carrier Code Group # Group Name Last Name
1
Client ID Last Name First Name Billed Amount Last Submit Dt Status
111111111 JONES JANE 2,500.00 R
Add
Copy
Delete
Undo All
Save
Find...
Print
Close

OTHER INSURANCE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
ICN	30	S	N
CLAIM FILING IND CODE	2	R	X
ADJUSTMENT GROUP CD	2	R	X
PAYER RESPONSIBILITY	1	R	A
REASON CODES 1-3	5	R	X
REASON AMTS 1-3	9	R	N
PAID DATE	8	R	N
PAID AMOUNT	9	R	N
POLICY HOLDER GROUP #	17	O	X
POLICY HOLDER GROUP NAME	14	R	A
POLICY HOLDER CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

OTHER INSURANCE ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim. This tab should also be used when Medicare does not pay any portion of the claim and all dollar fields below will contain zero amounts. Please use the crossover tab when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare.

The following fields are required when a "Y" is indicated in the other insurance indicator field on the Header Five Screen.

Release of Medical Data:

Select the appropriate value from the drop-down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop-down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

ICN:

Enter the original claim number, as assigned by the other insurance.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Claim Filing Ind Code:

Select the appropriate value from the drop-down box that identifies the type of other insurance claim that is being submitted. Select MA or MB when the denial is from Medicare.

Remarks: Required
Format: XX

Adjustment Group Cd:

Select the appropriate value from the drop-down box that identifies the general category of payment adjustment by the other insurance company.

Remarks: Required
Format: XX

Reason Codes:

Enter the code identifying the reason the adjustment was made by the other insurance carrier. At least one reason code and amount is required or use this field to indicate the reason Medicare denied the claim. The reason code can be found in the Implementation Guide by clicking on the following site**:** http://www.wpc-edi.com/ Follow the instructions below to retrieve the reason codes.

- Click on Code Lists

- Click on Claim Adjustment Reason Codes

Use this list of codes to indicate if a payment was made by OI or denied by OI.

Remarks: Required
Format: XXXXX

Reason Amounts:

Enter the amount associated with the reason code.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date that the other insurance carrier paid the claim (remittance advice date). Use this field to enter the date Medicare denied the claim.

Remarks: Required
Format: MM/DD/CCYY

Paid Amount:

Enter the amount paid by the other insurance carrier. An amount of zero (0) may be entered. This field is required if a value is entered in the Reason Code field on the other insurance screen and a payment has been received towards the claim from a third party.

This field is also used to indicate the Medicare Part B allowed amount when Medicare Part A coverage is exhausted or not applicable. Enter the sum of the Medicare paid amount, the coinsurance amount and the deductible amount located on the Medicare Explanation of Benefits.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Group #:

Select the group number from the drop-down list. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Remarks: Optional
Format: XXXXXXXXXXXXXXXX

Policy Holder Group Name:

This field is auto-plugged when a group number is entered and contains the name of the group that the other insurance is listed under and coincides with Group number.

Remarks: Required
Format: AAAAAAAAAAAAA

Policy Holder Carrier Code:

This field is auto-plugged when a group number is entered and contains the carrier code identifying the Other Insurance carrier from the drop-down list.

Remarks: Required
Format: XXX

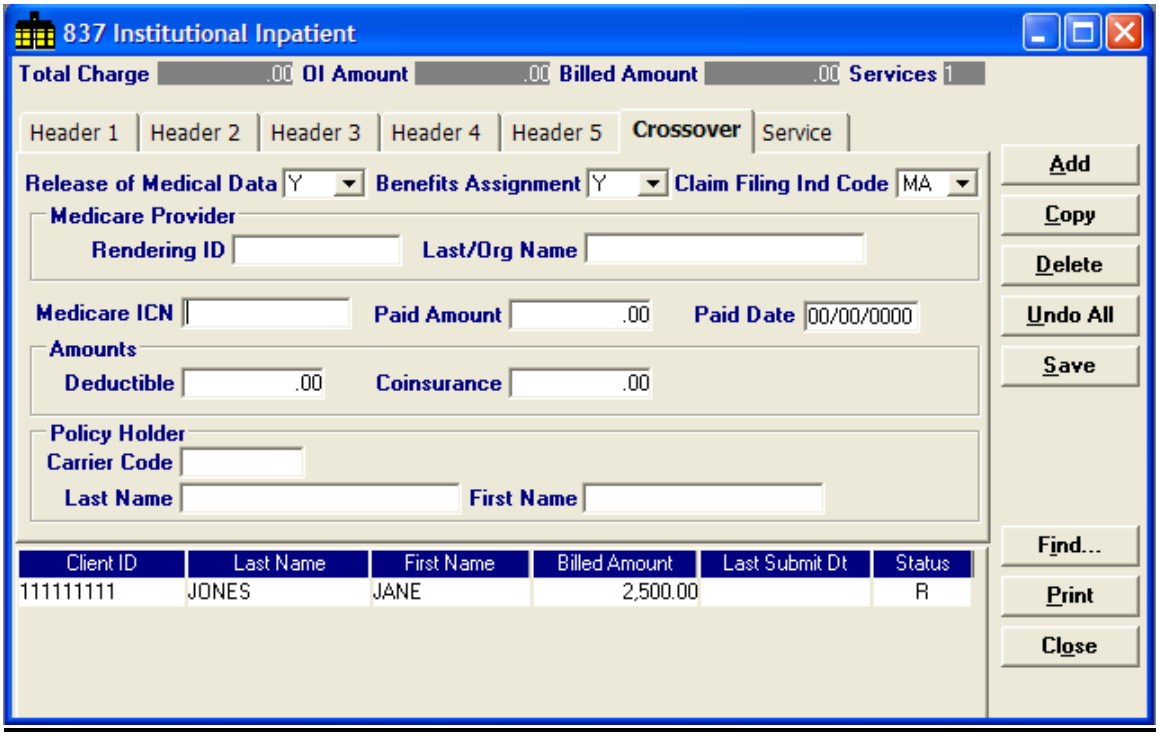
Policy Holder Last Name:
This field is auto-plugged when a group number is entered and contains the last name of the policyholder of the other insurance.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:
This field is auto-plugged when a group number is entered and contains the first name of the policyholder of the other insurance.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAA

CROSSOVER SCREEN



This tab should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. Please see the instructions on the Other Insurance tab if Medicare did not pay any portion of the claim. The Crossover Indicator on the Header 5 screen is defaulted to "N" for no. When this is changed to a "Y" for yes, the Crossover Tab is added to the claim form for entry.

CROSSOVER INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED/ OPTIONAL/ SITUATIONAL	ALPHA/ NUMERIC
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
CLAIM FILING IND CODE	2	R	X

MEDICARE PROVIDER RENDERING ID	10	R	N
MEDICARE PROVIDER LAST/ORG NAME	35	R	A
MEDICARE ICN	14	R	N
PAID AMOUNT	9	R	N
PAID DATE	8	R	N
AMOUNTS DEDUCTIBLE	9	R	N
AMOUNTS COINSURANCE	9	R	N
POLICY HOLDER CARRIER CODE	5	R	N
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

CROSSOVER ENTRY INSTRUCTIONS

The following fields are required when a "Y" is indicated in the Crossover Indicator field on the Header Five Screen. These fields should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. Please see the instructions on the Other Insurance tab if Medicare did not pay any portion of the claim. Use these fields for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Release of Medical Data:

Select the appropriate value from the drop-down box that indicates whether the provider has on file a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to a 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop-down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to a 'Y'.

Remarks: Required
Format: A

Claim Filing Ind Code:

Select the appropriate code from the drop-down box that identifies the type of other insurance claim that is being submitted. This field defaults to 'MA'.

Remarks: Required
Format: XX

Medicare Provider Rendering ID:

Select the appropriate identification number of the Medicare rendering provider from the billing provider list.

Remarks: Optional
Format: NNNNNNNNN

Medicare Provider Last/Org Name:

This field is auto-plugged once you select the rendering provider identification number.

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Medicare ICN:

Enter the claim number assigned to the claim by Medicare.

Remarks: Required
Format: XXXXXXXXXXXXX

Paid Amount:

Enter the dollar amount paid by Medicare for the service or claim.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date of the Medicare remittance advice on which these services are listed.

Remarks: Required
Format: MM/DD/CCYY

Amounts Deductible:

Enter the amount of the deductible that applies to the claim or detail identified by Medicare.

Remarks: Optional
Format: $$$$$$$cc

Amounts Coinsurance:

Enter the amount of coinsurance applied to the claim or detail identified by Medicare.

Remarks: Optional
Format: $$$$$$$cc

Policy Holder Carrier Code:

Select the carrier code that corresponds to the policyholder for this claim.

Remarks: Required
Format: XXX

Policy Holder Last Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required

Format: AAAAAAAAAAAAAAAAAAAAAAAA